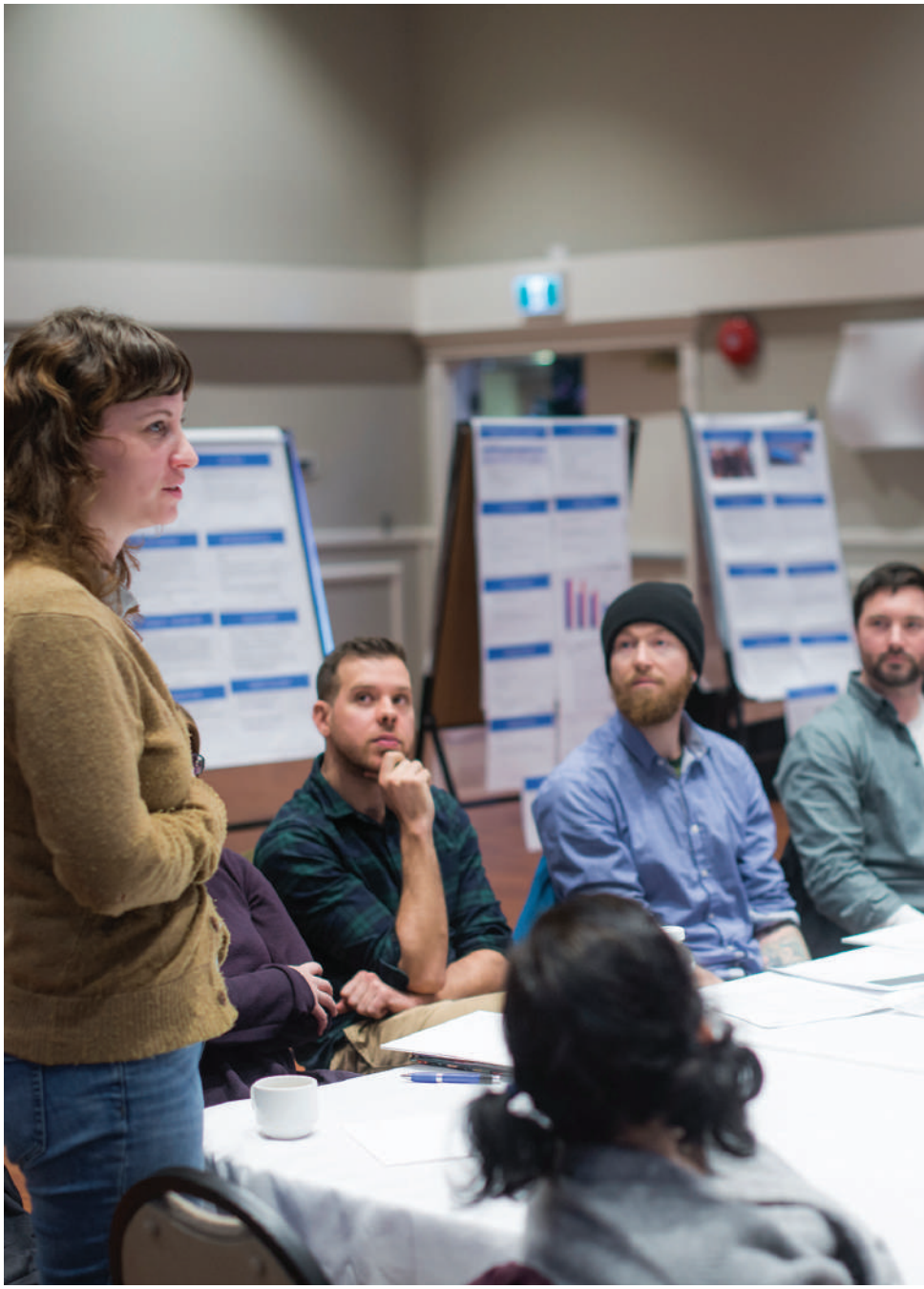
The BOOST QI Network

CHANGE PACKAGE

July 2020

CONTENT



Introduction

In 2016, a public health emergency was declared in British Columbia (BC) due to a dramatic increase in opioid-related overdose deaths. There were 995 confirmed overdose deaths in 2016, and in 2018, there were more than 1,300 deaths. Several targeted services were launched in response, but the number of opioid-related overdose deaths remains well above historical averages.

Evidence shows that a significant proportion of individuals with opioid use disorder (OUD) will reduce illicit opioid use and remain in treatment longer with appropriate doses of oral opioid agonist therapy (oOAT) such as methadone, buprenorphine/naloxone or slow release oral morphine (SROM). However, provincial data shows half of people receiving methadone achieve an optimal stabilizing dose. Similarly, while retention in care is a strong marker for better outcomes, fewer than half of those who start methadone are still in treatment at six months and this number is even lower at one year. Our current systems of care are not optimized to provide the highest quality healthcare to those living with OUD in BC. Together, we can make improvements across the continuum of OUD Care[1] and improve the lives of those we serve. This Change Package is a collection of change ideas that were tested by the Vancouver and Provincial BOOST Collaborative teams. It is designed to prompt your thinking and accelerate your team's ability to make improvements within your own context.

They have been grouped into four sections:

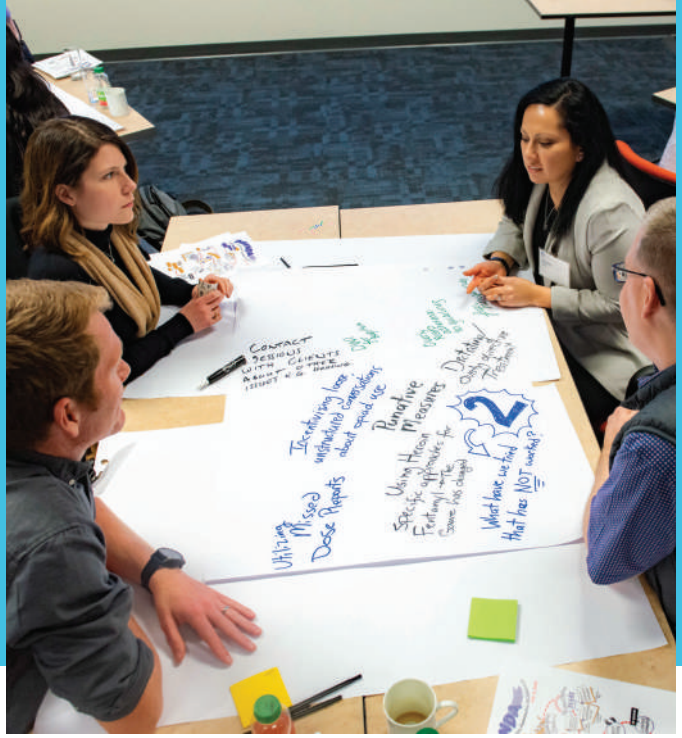
- **Screening and diagnosis**
- **Treatment initiation and active prescriptions**
- **Treatment retention**
- **The client voice and quality of life**

You will also see the top change ideas with the greatest impact highlighted in each section (in blue text) where feedback was provided. Test the ideas of interest in your own system using the PDSA method described in the Preparation Resource Manual. Each small test of change can collectively make a substantial difference to improve care for those living with OUD.

[1] The Continuum of OUD Care refers to the comprehensive and connected array of health services spanning all levels of intensity of care within the community and health system.

CHANGE **IDEAS**

A significant predictor of treatment success is shorter time to treatment from diagnosis. In addition, research shows that the first four weeks of treatment are the highest risk period for all-cause mortality and overdose-related mortality. It is essential for clients to feel supported and respected through the process from diagnosis to treatment initiation.



Screening and Diagnosis

- Empanelment: Identify your population of focus by using a standardized diagnostic code in the client's paper/electronic medical chart
- Consider expanding screening for high-risk populations (e.g. people with chronic pain)
- Generate a list of all clients in the clinic on long-term opioids and screen them for OUD at their next regular visit
- Inclusion of peer staff
- Engaging and retaining young people on an outreach basis (for example, contingency management and offering candy during appointments)

Treatment Initiation and Active Prescriptions

- ***Identify and eliminate policies or guidelines that are acting as barriers to treatment initiation and deterring engagement***
- ***Offer treatment options that align with client preferences***
- ***Provide team-based care by utilizing staff to full scope of practice, i.e: who is the best suited team member to perform an initial assessment, screening education, etc.***
- Suboxone home starts and microdosing
- Simplify intake process
- Appointment reminder calls
- Arrange for follow-up assessment and treatment for OUD on the same day
- Open up drop-in times
- Rapid inductions
- Low barrier front desk and waiting room
- Opening up a low barrier model of service; accepting walk-ins and expanding this to evenings and weekends
- Reduce time needed for inductions: door-to-dose
- Liaise with stabilization clinics

Research shows retention on OAT is associated with substantial reductions in all-cause mortality and overdose-related mortality in people with opioid use disorder. In addition, longer treatment duration is associated with a reduction in illicit opioid use and improved retention. Although a high proportion of clients are initiated on treatment, only one third are retained in care after a year. This presents a great opportunity for improvement for teams with demonstrated benefits to clients.

CHANGE **IDEAS**

Treatment Retention

- ***Establish a partnership with the pharmacies your clients use to ensure missed doses are communicated to your team***
  - ***Send a letter of introduction to the pharmacy along with a prescription***
- ***Optimize use of outreach resources especially for vulnerable clients***
- ***Establish a proactive monitoring and notification system of prescription status for all clients with OUD in your care***
  - Identify clients with expired or soon to expire prescriptions for OAT
  - Identify clients with missed doses of OAT
  - Implement standardized procedure for addressing missed doses and expired prescriptions
  - Ensure that there is up-to-date contact information for the client and their pharmacy
  - Tracking new starts and vulnerable clients
  - Weekly review of Medinet/Pharmanet
- Collaborate with other clinics for bridging prescriptions
- Develop a process not to end prescriptions on Friday
- Generate a list of all clients in the clinic on long-term opioids and screen them for OUD at their next regular visit
- Offer incentives to improve retention
- Follow-up phone calls in case of a missed doses
- Track adherence rates to OAT and upscale support for those with low adherence rates
- Establish a standardized procedure to follow-up with no-shows

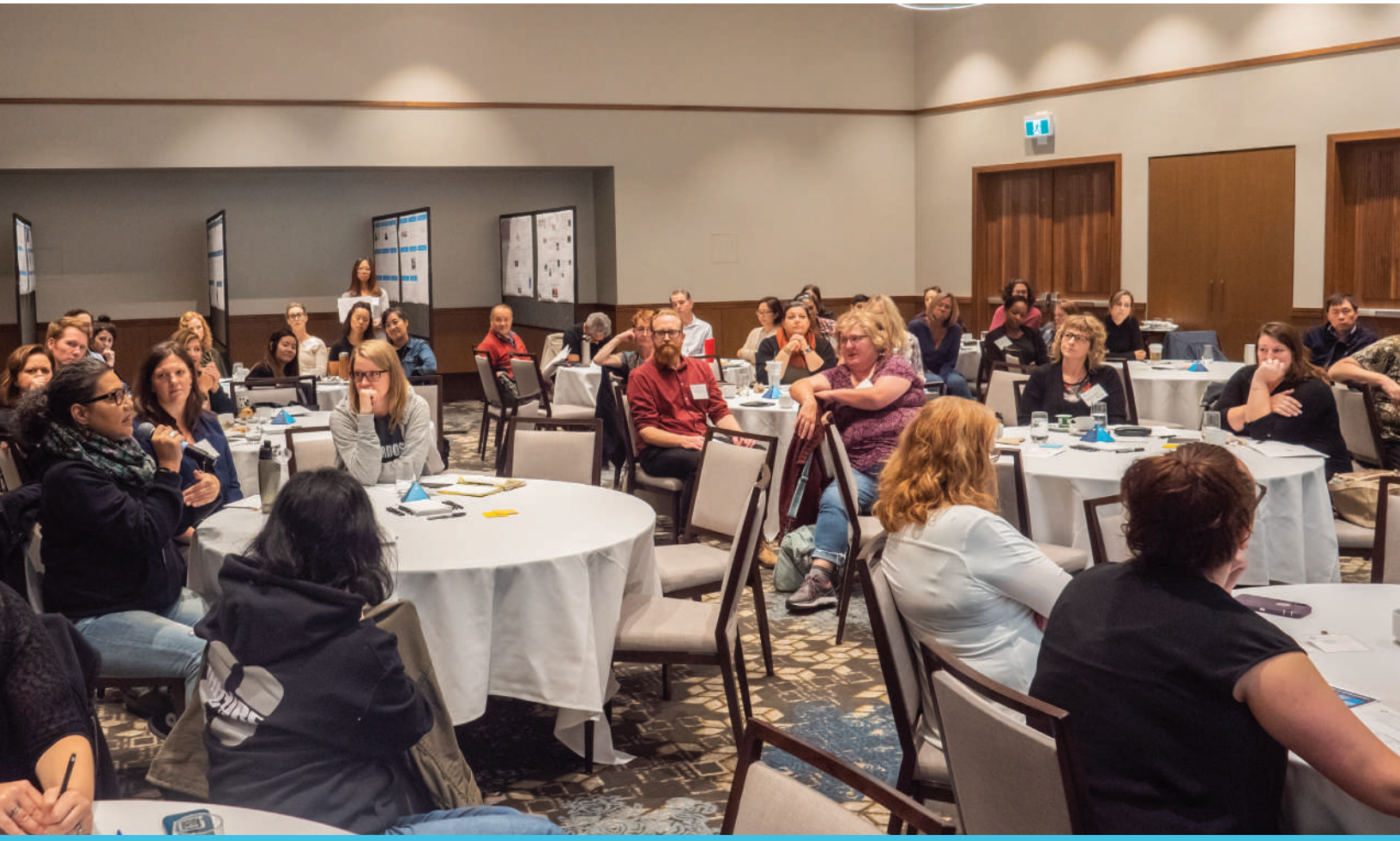
Even when linked to care, a significant number of clients do not engage in ongoing care for a variety of reasons. Clients are especially vulnerable during the period just following the initiation of OAT and after treatment cessation, and benefit from the support of a caring healthcare team.

For clients who engage in care initially, retention in care is not guaranteed. System issues such as inconvenient access, a negative client experience, lack of cultural sensitivity, and lack of systematic follow-up can contribute. Client-centric issues such as substance use, mental health issues and social determinants of health may also interfere with ongoing engagement.

CHANGE **IDEAS**

The Client Voice and Quality of Life

- ***Develop a client survey: outline a process on who, when and how often the survey will be distributed***
- ***Develop a process to analyze and review the data collected***
- Education material for clients during start of therapy and before a referral
- Develop a plan to analyze the results acquired from the PROMIS scale
- Provide food and gift cards to clients
- Utilize the PROMIS scale: develop a process on who, when and how often to be administer



REFERENCES **& RESOURCES**

1. Provincial Health Officer Declares Public Health Emergency. April 14 2016. Available from: https://news.gov.bc.ca/10694

2. Illicit Drug Overdose Deaths in BC Jan 1, 2008 – June 30, 2018. BC Coroners Service. Available from: http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

3. BC Opioid Substitution Treatment System. Office of the Provincial Health Officer Performance Measures 2014/2015 – 2015/2016. Available from: http://www2.gov.bc.ca/assets/gov-/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/bc-ost-system-measures-14-15-and-15-16.pdf

4. Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ 2017;357.

5. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

ACKNOWLEDGEMENTS

This report was prepared by members of the BOOST Project Team (boostcollaborative@cfenet.ubc.ca), with a special thanks to Eduardo Caceres (BC-CfE Communications) for his design support.

The BOOST QI Network is funded by Health Canada's Substance Use and Addictions Program (SUAP) and the Shared Care Committee (SCC), with in-kind support from the BC-CfE